STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155779	A. BUILDING 01 B. WING	08/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HEALTH CAMPUS	9730 PRAIRIE LAKES BOULEVARD EA NOBLESVILLE, IN46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/08/11 Facility Number: 012305 Provider Number: 155779 AIM Number: 200987990 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Prairie Lakes Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This facility consists of two separate one story buildings consisting of the Main Campus building and the Legacy building. Each building is Type V (111) construction and fully sprinklered and has a fire alarm system with smoke detection in the corridors, resident sleeping rooms	K0000	Prairie Lakes Health Campus submits this plan of correction in response to the allegations of noncompliance cited during the Life Safety Code Survey conducted on August 8, 2011.Please accept this plan of correction as the providers letter of credible allegation of compliance effective September 5, 2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	and areas open to the corridor. The facility has a capacity of 130 and had a census of 63 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/15/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0038 SS=F	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 1. Based on observation and interview, the facility failed to ensure 9 of 9 exit door electromagnetic locks remained unlocked while the fire alarm was activated. LSC 18.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2(e) states activation of the building automatic sprinkler or fire detection system, if provided, automatically unlocks the doors and the doors remain unlocked until the fire protective signaling system has been manually reset. This deficient practice could affect all residents, staff and visitors in the Legacy building.	K0038	K 038**It is the practice of this provider to ensure that exit access is arranged so that exits are readily accessible at all times; however in response to the 2567 findings, the following measures and corrective actions have been taken:** Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: The Legacy unit was designed as a secured memory care unit with the exit doors remaining locked by an electromagnetic locking device. The doors are wired into the fire detection system to automatically release if the system was activated and to	09/05/2011

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	Findings include: Based on observations with the Administrator and the Director of Plant Operations during a tour of the facility from 1:10 p.m. to 3:45 p.m. on 08/08/11, the electromagnetic locks on all nine Legacy building exit doors did not release and remain unlocked when the fire alarm was activated at 3:24 p.m. Based on interview at the time of the observations, the Director of Plant Operations acknowledged each of the nine Legacy building exit doors electromagnetic locks should have released and remained unlocked when the fire alarm was activated. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 9 Main Campus building exits was readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. This deficient practice could affect any resident, staff or visitor needing to exit the Main Campus building from the Pioneer Hall exit.		remain unlocked until the fire protection signaling system is manually reset. During previous inspections and monthly fire drill testing, the doors have worked as designed and released with the activation of the fire alarm. During this inspection the system malfunctioned and the electromagnetic locks remained engaged after the fire alarm was activated. The provider's vendor was immediately contacted and informed of the malfunction and priority service was scheduled. The vendor's analysis detected a faulty circuit board which did not allow the electromagnetic locks to release. The circuit board was replaced and the system was returned to proper functioning status. Identification of other residents having the potential to be affected by the same alleged deficient practice and the corrective actions implemented: All Residents residing on the Legacy Unit have the potential to be affected by the alleged deficient practice.	

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	Findings include: Based on observation with the Administrator and the Director of Plant Operations during a tour of the facility from 1:10 p.m. to 3:45 p.m. on 08/08/11, the exit discharge outside the Main Campus building Pioneer Hall exit was blocked by a parked car in the public way. Based on interview at the time of observation, the Administrator stated visitors who have been granted the building entrance access code may enter the Main Campus building from the Pioneer Hall entrance and usually don't park at the exit discharge but acknowledged the exit discharge to the public way was blocked by a visitor's parked car. 3.1-19(b)		Measures implemented and systemic changes made to ensure that the alleged deficient practice does not recur: The fire drill report sheet has been modified to include inspection of the electomagnetic locks to ensure proper release with activation of alarm. Each time that the fire alarms are activated during a drill the electromagnetic locks will be inspected and results will be documented, any malfunctining of the system will immediatedly be reported to the Executive Director and or the Director of Plant Operations. How the corrective action will be monitored to ensure the alleged deficient practice will not recur: Director of Plant Operations or Designee will conduct monthly fire drills and system inspections. Results of the fire drills and system inspections will be reported to the Governing Quality Assurance committee	

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			monthly for one (1) quarter and quarterly thereafter. Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: During this inspection a visitor had parked her car at the end of the sidewalk long enough to run in some supplies to their family member, blocking the public way. The visitor was immediatedly asked to move her car. A sign was added marking this area as a no parking zone. Identification of other residents having the potential to be affected by the same alleged deficient practice and the corrective actions implemented: Any resident needing to exit the Main Campus building using the Pioneer Hall exit has the potential to be affected by the alleged deficient practice. Measures implemented and systemic changes made to ensure that the alleged deficient practice	

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			does not recur: Staff will be inserviced and educated to inform them of the need for building exits to remain accessible and for the sidewalks that lead to the public way to remain unblocked at all times. How the corrective action will be monitored to ensure the alleged deficient practice will not recur: The ED or designee will observe that the no parking sign remains in place and that the exits remain unblocked. This audit will occur weekly for four weeks, monthly for 5 months and quarterly thereafter to ensure compliance. Results of the audit will be reported to the Quality Assurance Committee for a minimum of 6 months then randomly thereafter.	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 2 of 2 emergency generators were equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110,	K0144	**It is the practice of this provider to ensure that our Generators are inspected weekly and exercised under load for 30 minutes per month; however in response to the 2567 findings, the following measures and corrective**	09/05/2011

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	Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located elsewhere on the premises where the prime mover is located outside the building. This deficient practice could affect all occupants in the Main Campus building and in the Legacy building. Findings include: Based on observations with the Administrator and the Director of Plant Operations during a tour of the facility from 1:10 p.m. to 3:45 p.m. on 08/08/11, no evidence of a remote shut off device was found for the Main Campus building emergency generator and for the Legacy building emergency generator. The Main Campus building emergency generator is rated at 125 kW and the Legacy building emergency generator is rated at 80 kW. Each generator was manufactured in December 2009. Based on interview at the time of observation, the Director of Plant Operations acknowledged each emergency generator was not equipped with a remote shut off device. 3.1-19(b)		**actions have been taken:** K 144 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: A remote manual shut off device was installed and tested by the providers vendor. Identification of other residents having the potential to be affected by the same alleged deficient practice and the corrective actions implemented: All residents have the potential to be affected by the alleged deficient practice. Measures implemented and systemic changes made to ensure that the alleged deficient practice does not recur: The staff will be inserviced on the purpose, and protocal for use of the manual shut off device. How the corrective action will be monitored to ensure the alleged deficient practice will not recur:	

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			The Director of Plant Operations will conduct monthly inspections of the emergency generator to include inspection of the remote manual shut off device. Results of the system inspections will be reported to the Governing Quality Assurance committee monthly for one (1) quarter and quarterly thereafter.	